Patient Information

Name____

Primary Cell Phone__________________________________

Secondary Phone____________________________________

Address____

City, State ___________________________________ ZIP ______________

Social Security # _________________________ Date of Birth____________________

E-Mail (Please Print)____

Guardian/Caretaker *Name/contact number*____

Gender: Male Female **Is the applicant a dependent child?** Yes No

Marital Status: Single Married Widowed Divorced

Spouse Name____

Emergency Contact Information

Emergency Contact_______________________________ Relationship_______________

Phone Number _____________________

How did you hear about Audio Recovery?

Relative/ Friend/ Dr. Referral (Please print their name) ______________________________

Print Media Internet Social Media

What would you consider to be your chief communication problems? In what situation(s) do you notice the most difficulty hearing or understanding? ________________________________

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Do you now, or have you ever, worn a hearing aid? **Yes** **No** If yes - for how long? ________

Would you consider your lifestyle? **Active** **Somewhat Active** **Not active**

Do you have family history of hearing loss?	Yes	No
Have you been exposed to ongoing loud noise?	Yes	No
Have you had ringing, roaring, or buzzing in the ears in recent years?	Yes	No
Have you experienced episodes of social isolation?	Yes	No
Have you been treated for clinically diagnosed depression?	Yes	No
Have you become more unsteady on your feet and fallen in recent years?	Yes	No
Have you or a family member been diagnosed with Dementia or Alzheimer's?	Yes	No
Have you received cancer treatment in recent years?	Yes	No
Have you ever had ear surgery?	Yes	No

If Yes When? ______________ Which ear? ____________ Procedure? ________________

Do you have difficulty hearing in these areas?

With one person in a quiet environment?	Yes	Sometimes	No
With one person in background noise, such as a restaurant?	Yes	Sometimes	No
While at home, work, or play?	Yes	Sometimes	No
While on your phone or watching TV?	Yes	Sometimes	No
While with others in the car?	Yes	Sometimes	No
In small groups of people (2-3) in a quiet environment?	Yes	Sometimes	No
In large groups of people (4+) in background noise?	Yes	Sometimes	No

If services are rendered, I understand that I am responsible for any account balance. I am aware of this office's Notice of Privacy Practices and fully understand my privacy rights as a patient of ARI. If the patient is a minor or otherwise incapacitated, the law requires that the legally authorized guardian or custodian sign for them.

Patient Signature ______________________________ Date ___________________________